Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $667.00 for dates of service 03/07/01 through 03/26/01.

   b. The request was received on 01/30/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 03/19/02
   b. HCFA(s)-1500
   c. TWCC 62 forms and Medical Audit summaries
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Responses to the Request for Dispute Resolution dated 02/06/02 and 06/26/02
   b. HCFA(s)-1500
   c. TWCC 62 forms and Medical Audit summaries
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The Commission's case file did not contain a Notice of Medical Dispute sign sheet. The carrier submitted two initial responses; one dated 02/06/02 and one dated 06/26/02. The carrier did not submit a 14 day response to the request for dispute. All information in the case file will be reviewed.

4. The return receipt card notice of sending the provider's 14 day additional response to the carrier is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 03/19/02
   "…procedure code 97110 has been accepted for payment but the insurance company is only paying for one unit and denying each additional unit after that. The insurance company is stating that the nature of the treatment supports the type of therapy provided

in a group setting where the exercises were performed in a group setting with minimal instruction and supervision by the therapist….We do not treat any patients in a group setting, all therapy is carefully supervised by the Therapist [sic]."

2. Respondent: Letter dated 06/26/02:
"The (Carrier) received a TWCC-60 from the above-mentioned requester. Pursuant to Commission rule [sic] 133.307 (e)(2) sections (A) through (C) and 133.307 (e)(3) the (Carrier) files the attached, completed TWCC-60 and related items. As the respondent in this dispute, the carrier further asserts it has properly completed Parts II, III, V, and VI of the TWCC-60 form…"

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 03/07/01 and extending through 03/26/01.

2. The provider billed a total of $1,194.00 for the disputed dates of service.

3. The carrier reimbursed the provider a total of $245.00 for the disputed dates of service.

4. The total amount in dispute for dates of service is $667.00.

5. The carrier denied services by codes:
"A – PREAUTHORIZATION REQUIRED BUT NOT REQUESTED";
"COND - T – F,N BASED ON THE TWCC TRMT [sic] GUIDELINE'S GROUND RULE 2.A.I-VII CHANGE IN THE PATIENT'S CLINICAL CONDITION AND/OR PROGRESSION HAS NOT BEEN DOCUMENTED TO SUPPORT 1:1 THERAPY. PATIENT'S CONDITION SUPPORTS THERAPY IN A GROUP SETTING";
"F – DDUP – REIMBURSED IN ACCORDANCE WITH THE TEXAS MEDICAL FEE GUIDELINE.";
Medical audits dated 11/15/01 for all dates in dispute state, "Based on the TWCC Treatment Guideline's Ground Rule 2, A, I-VII, change in the patient's clinical condition and/or progression has not been documented to support one-to-one therapy. The patient's condition and nature of treatment supports the type of therapy provided in a group setting where exercises are performed by the patient with minimal instruction and supervision by the therapist."

6. The carrier's response is timely. No other EOB(s) or medical audits were noted. Therefore, the Medical Review Division's decision is rendered based on those denial codes submitted to the provider prior to the date this dispute was filed.

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
03/07/01	97010 97014 97110	$20.00 $29.00 $135.00	$0.00 $0.00 $0.00	A	$11.00 $15.00 $35.00 per 15 mins.	Rule 134.600 (h) (10)	Rule 134.600 (h) (10) states, "The health care treatments and services requiring pre-authorization are: (10) physical therapy …beyond eight weeks of treatment." The provider received verbal notification of preauthorization for physical therapy services on 02/08/01. The preauthorization form states for "requested services; 02/05/01-03/05/01", yet the authorization was not given until 02/08/01 which meant the services could begin 02/09/01. Dates of service prior to the preauthorization date would not fall within the requirement for preauthorization. The preauthorization form states, "Preauthorization is effective 30 days from date of verbal notification. Four weeks from 02/09/01 is 03/08/01, therefore, date of service 03/07/01 was preauthorized. Reimbursement in the amount of **$131.00** is recommended.
03/09/01 03/12/01 03/14/01 03/20/01 03/26/01	97110 97110 97110 97110 97110	$135.00 $135.00 $135.00 $135.00 $180.00	$35.00 $35.00 $35.00 $35.00 $35.00	T,N,F T,N,F T,N,F T,N,F T,N,F	$35.00 per 15 mins.	MFG MGR (I) (A) (9) (b); (I) (A) (10) (a); CPT descriptor	MFG MGR (I) (A) (9) (b) states, "Procedures (Supervision by the doctor or HCP, in either a group (97150) or one-to-one (97110-97139) setting, is required)." (I) (A) (10) (a) states, "A physical session is defined as any combination of four modalities…procedures (97110-97150) and/or physical medicine activities and training…" The maximum amount of time allowed per session is two hours." CPT code 97110 is a one-to-one, timed code. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." The Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The provider failed to document legible duration of each activity performed except for dates of service 03/12/01 and 03/14/01. Dates of service 03/12/01 documented 20 minutes and 03/14/01 documented 25 minutes of activity on the stairmaster. The provider failed to document the physical therapy time frames to support that the services were rendered as billed. The progress notes indicate that the claimant is experiencing "min pain", pain levels of "1-2, 2-3, and worst 3-7, avg 2/10 ", "better now", "Has occasional pain", "Has definitely improved", and "cont to show slow, steady progress." The provider failed to indicate any medical conditions or symptoms that would mandate one-on-one supervision for an entire session or over an entire course of treatment. The notes do not reflect the need for one-on-one supervision tapering off over time as the claimant becomes more familiar with the exercises. The provider stated in their letter requesting medical dispute that, "We do not treat any patients in a group setting, all therapy is carefully supervised by the Therapist." Because a provider has no group therapy is not a medical reason to provide one-on-one therapy to a claimant. The provider failed to indicate that the services were performed on a one-on-one basis. There is no direct statement indicating who is conducting the physical therapy sessions with the claimant. The activities listed do not clearly indicate which activities would require a one-to-one session. The physical therapy session reports are unsigned by the provider. **No** reimbursement is recommended.

03/09/01 03/21/01 03/23/01	97010 97110 97110	$20.00 $135.00 $135.00	$0.00 $35.00 $35.00	F T,N,F T,N,F	$11.00 $35.00 per 15 mins. For CPT code 97110	Rule 133.1 (a) (3) (B); Rule 133.307 (e) (1) (A)	Both rules indicate that a complete request for medical dispute must include HCFA(s) for the disputed services. The provider failed to submit HCFA(s) for referenced dates of service and CPT codes. **No** reimbursement is recommended.
Totals		$1,194.00	$245.00				The Requestor **is** entitled to reimbursement in the amount of **$131.00.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $131.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 25th day of July 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.